Flexible Spending Accounts
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Flexibility Spending Accounts (FSAs) enable you to convert taxable income to tax-free health and dependent care benefits. By electing to deposit a portion of your salary to an FSA, you are redirecting your money into an account used to pay health care or dependent care qualified expenses that would otherwise be paid with taxed income.

Two Flexible Spending Account types are available:

1) Health Care FSA funds can be used to pay your and your family’s medical, dental and vision care expenses that are not reimbursed under any other health plan coverage or claimed as a tax deduction on your tax return.

2) Dependent Care FSA funds enable you to make pre-tax dependent care payments for qualifying individuals you are responsible for while you work, such as children under the age of 13 or day care expenses for disabled individuals.

Funds designated to FSAs are exempt from Federal and State taxes. At the current time, your FSA contributions are also exempt from Social Security taxes, but this exemption is subject to change. You owe no tax on funds deposited to the FSA at the time of contribution nor on funds reimbursed from the FSA, which means your funds remain tax-free on your tax return. Illustrated below are two common tax brackets projecting Federal and State savings separate from Social Security savings.

<table>
<thead>
<tr>
<th>Annual Contribution</th>
<th>15% Federal/5% State</th>
<th>25% Federal/5% State</th>
<th>7.65% Social Security</th>
</tr>
</thead>
<tbody>
<tr>
<td>$260</td>
<td>$52</td>
<td>$78</td>
<td>$20</td>
</tr>
<tr>
<td>$520</td>
<td>$104</td>
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<tr>
<td>$1,040</td>
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<td>$1,800</td>
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<tr>
<td>$2,500</td>
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<td>$750</td>
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<tr>
<td>$3,300</td>
<td>$660</td>
<td>$990</td>
<td>$252</td>
</tr>
<tr>
<td>$5,000</td>
<td>$1,000</td>
<td>$1,500</td>
<td>$383</td>
</tr>
</tbody>
</table>

*Actual taxes could vary.
FSAs – Facts to Consider When Making Your Election

Administrator: Your employer is the plan administrator. M&I Benefits Services of Marshall & Ilsley Trust Company N.A. acts as the plan's administrative agent and can be reached at 1-800-236-3539, https://www.miwebflex.com or P.O. Box 2517, Appleton, WI 54912-2517.

Enrollment: During the open enrollment period prior to each plan year, you may elect one or both FSA options. FSA elections do not automatically renew, so you must make an election each year. If you are rehired during a plan year, talk to your benefits department regarding participation. Your election will be irrevocable and may only be cancelled or changed if you experience a qualified mid-year event (see Mid-Year Election Change).

Qualified Individuals: You may seek reimbursement for you, your spouse and other "qualifying individuals" for eligible expenses from the respective pre-tax spending account. A person who qualifies for Health Care FSA or Dependent Care FSA benefits may not always qualify for a tax deduction. This booklet provides some guidelines to help you determine qualified FSA individuals.

Plan Years and Periods of Coverage: Your Summary Plan Description (SPD) indicates your plan year, which is generally the 12-month period during which your salary is reduced to meet your FSA election. Your coverage period is generally the same as your plan year, but may be shorter if you gained FSA benefit eligibility after the plan year began or lost it before the plan year ended.

Coverage for a specific plan year ceases at the end of that plan year unless your employer extends FSA coverage. Review your SPD for any coverage extension.

Contributions: You may choose to contribute to two separate spending accounts: a Health Care FSA and a Dependent Care FSA. Each account is funded by pre-tax payroll deductions taken throughout the plan year before payroll taxes are calculated. Verify your annual election information and payroll account deductions. Notify your employer immediately if an error was made.

Mid-Year Election Change: FSA elections are generally irrevocable for the plan year. However, some qualifying events allow mid-year election changes. Day care cost and coverage changes consistent with a qualifying event are permitted so long as the day care provider is not a relative. Events allowing consistent Dependent Care FSA or Health Care FSA changes may include: leave of absence; special enrollment rights for you, your spouse or qualified individuals; court ordered judgments; change in marital status; change in the number of qualified individuals; employment changes affecting eligibility for you, your spouse or a qualified individual; and a spouse or qualified individual's eligibility change under their employer's plan. Please see your benefits department for full details. Health Care FSA elections cannot be changed mid-year due to illness, costly medical procedures, and health insurance coverage or cost changes.

HSA Coverage: If you or your spouse are covered by a High Deductible Health Plan (HDHP) and/or you intend to contribute to a Health Savings Account (HSA) during the plan year, you cannot contribute to the traditional full health coverage Health Care FSA. Ask your benefits department if a Limited Health Care FSA option is available. A Dependent Care FSA election will not be affected by HSA coverage.

Coverage Termination: Certain events during the plan year such as employment termination, transfer to a benefit-ineligible position, death or taking an unpaid leave of absence may result in FSA coverage termination. You or your beneficiaries should contact your benefits department immediately if you experience or expect to experience such an event.
If you terminate or transfer to a benefit-ineligible position, your employer will offer you continuation coverage under COBRA or a similar continuation option for the Health Care FSA if you are eligible. If you are not eligible for coverage continuation or if you choose not to continue coverage, your coverage generally extends through the last day in your benefit-eligible position and only expenses incurred through this date are reimbursable. You may continue to submit Dependent Care FSA claims incurred through the plan year (and applicable plan extension) after termination until your account balance is exhausted.

Unpaid events or leaves of absence such as Family Medical Leave, military leave, strike or lay-off may affect FSA coverage continuation. Contact your benefits department prior to any leave to discuss FSA coverage continuation options. If you choose to cease Health Care FSA coverage during your leave, expenses incurred during the leave will not be eligible for reimbursement.

Year-End Account Balance: At the close of your FSA plan year (and any applicable extension), you are given a “run-off” period during which you can continue to submit eligible expenses against your FSA balance(s). See your Summary Plan Description ( SPD) for the length of the run-off period. Account balances remaining in your FSA after the “run-off” period expires, cannot be returned to you or carried forward to a new plan year. In accordance with IRS regulations, you forfeit these funds.

Social Security: If you earn less than the Social Security wage base and participate in an FSA, your Social Security benefit at retirement may be slightly lower. Possible reductions will vary by individual, but pre-tax savings now usually exceed the potential Social Security reduction in later years.

Privacy: M&I Benefits Services collects, stores and transfers necessary health information for you, your spouse and qualifying individuals in compliance with HIPAA privacy rules. If you want someone else to discuss FSA claim information on your behalf, you should sign a Personal Health Information ( PHI) release form and/or share your on-line web account access with that individual.
Health Care Flexible Spending Account

This account reimburses out-of-pocket health care services for you, your spouse and other qualifying individuals. The date of service, not the date you pay for the service, generally determines the plan year from which the expense can be reimbursed. You can use the Health Care FSA whether or not you carry your employer’s health insurance plan. While insurance premiums are not reimbursable from your Health Care FSA, virtually all employers deduct insurance premiums on a pre-tax basis for your employer group health insurance plan(s).

Section 213 of the Internal Revenue Code defines eligible health care as expenses primarily incurred to alleviate a physical or mental defect or illness in order to diagnose, cure, mitigate or treat a disease and for treatments affecting any part or function of the body. Usually included in this definition are medical or dental deductibles, HMO or drug co-payments, charges in excess of “usual and customary” costs, dental services, vision exams, prescription eyewear, prescription drugs and over-the-counter medicines used to treat medical conditions (i.e., injury, headache, cough, etc.). Note that the excessive purchase of eligible products is not permitted by the IRS and these claims may be denied.

Expenses solely for cosmetic reasons or expenses merely beneficial to one’s general health are not eligible. You cannot receive FSA reimbursement for expenses paid by insurance, claimed as an income tax deduction, reimbursed by a Health Savings Account (HSA) or paid by another source. Individuals intending to contribute to an HSA during the next plan year should ask their benefit department for Limited Health Care FSA information.

Whose health care expenses can I seek reimbursement for?
You can be reimbursed for eligible expenses for yourself, your legal spouse and other qualified individuals. A qualified individual for health care benefit purposes is generally defined as: 1) a child or relative under age 19 (under age 24 if a full-time student) who lives with you over half the year so long as he/she does not provide over half of his/her own support, and 2) a relative or non-relative over the age of 19 for whom you provide over half of their support. A non-relative must also live with you over half the year. Your tax advisor can counsel you if you have questions regarding other individuals for whom you pay medical expenses.

The list on the next page identifies health-related expenses often submitted for traditional Health Care FSA consideration and separates them as eligible and ineligible. This list is not meant to be all-inclusive. If you have questions regarding a specific expense, please call an M&I Benefits Services client service representative at 1-800-236-3539 for clarification before making your election.
## Eligible Expenses

<table>
<thead>
<tr>
<th>Category</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
<td>In-patient therapy for mental or nervous disorders</td>
</tr>
<tr>
<td>Alcoholism/drug treatment</td>
<td>Insulin &amp; diabetic supplies</td>
</tr>
<tr>
<td>Allergy treatments and drugs</td>
<td>Lab fees</td>
</tr>
<tr>
<td>Artificial limbs/teeth</td>
<td>Lamaze (for mother)</td>
</tr>
<tr>
<td>Birth control pills</td>
<td>Language training (dyslexia or disability)*</td>
</tr>
<tr>
<td>Braille books &amp; magazines (cost exceeding printed edition)</td>
<td>Learning disability tuition*</td>
</tr>
<tr>
<td>Car modifications for handicapped</td>
<td>Mammograms</td>
</tr>
<tr>
<td>Chiropractic care</td>
<td>Massage therapy (for medical reason)*</td>
</tr>
<tr>
<td>Co-insurance (amount not paid by insurance)</td>
<td>Medical conference admission*</td>
</tr>
<tr>
<td>Contact lenses &amp; supplies</td>
<td>Monitoring devices</td>
</tr>
<tr>
<td>Co-pays and deductibles</td>
<td>Nursing services</td>
</tr>
<tr>
<td>Dental care</td>
<td>Occlusal guard to prevent teeth grinding</td>
</tr>
<tr>
<td>Dermatologist fees</td>
<td>Optometrist fees</td>
</tr>
<tr>
<td>Diagnostic tests</td>
<td>Orthodontic treatment</td>
</tr>
<tr>
<td>(only services within the plan year)*</td>
<td>Orthopedic shoes</td>
</tr>
<tr>
<td>Doctor's fees</td>
<td>Over usual &amp; customary charges</td>
</tr>
<tr>
<td>Eye exams</td>
<td>Over-the-counter drugs and medicines</td>
</tr>
<tr>
<td>Eyeglasses/sunglasses (prescription &amp; reading)</td>
<td>(antacids, pain relievers, cold medicine, etc.)</td>
</tr>
<tr>
<td>Flu Shots</td>
<td>Oxygen</td>
</tr>
<tr>
<td>Guide dogs</td>
<td>Periodontal fees</td>
</tr>
<tr>
<td>Handling &amp; shipping</td>
<td>Physical examinations</td>
</tr>
<tr>
<td>Hearing aid/batteries/exams</td>
<td>Prescription drugs**</td>
</tr>
<tr>
<td>Hearing treatment</td>
<td>Prosthetic devices</td>
</tr>
<tr>
<td>Hospital services</td>
<td>Psychiatric care</td>
</tr>
<tr>
<td>Infertility treatment</td>
<td>Psychoanalysis</td>
</tr>
</tbody>
</table>

*Requires written proof of medical necessity from your doctor

**Eligible unless prescribed for a specific cosmetic purpose

## Ineligible Expenses

<table>
<thead>
<tr>
<th>Category</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast pumps*</td>
<td>Illegal treatment/operations/drugs</td>
</tr>
<tr>
<td>Cosmetic treatments/drugs*</td>
<td>Imported prescription drugs</td>
</tr>
<tr>
<td>Elective counsel (dietary, marriage, etc.)*</td>
<td>Insurance policies</td>
</tr>
<tr>
<td>Electrolysis</td>
<td>Liposuction</td>
</tr>
<tr>
<td>Estimates</td>
<td>Long-term care insurance/services</td>
</tr>
<tr>
<td>Expenses claimed on tax return</td>
<td>Long-term storage of sperm or embryo*</td>
</tr>
<tr>
<td>Expenses paid by another source</td>
<td>Massage therapy (for general well being)</td>
</tr>
<tr>
<td>Exercise classes*</td>
<td>Meals</td>
</tr>
<tr>
<td>Exercise equipment*</td>
<td>Medicare premiums</td>
</tr>
<tr>
<td>Finance charges</td>
<td>No show/missed appointment fees</td>
</tr>
<tr>
<td>Food/beverage for nutritional purpose</td>
<td>Over-the-counter vitamins*</td>
</tr>
<tr>
<td>Genetic testing*</td>
<td>Personal use items*</td>
</tr>
<tr>
<td>Group health insurance premiums</td>
<td>Physician retainer fees</td>
</tr>
<tr>
<td>Hair loss/replacement treatment or Rx</td>
<td>Plastic surgery*</td>
</tr>
<tr>
<td>Health club memberships*</td>
<td>PPO provider discounts</td>
</tr>
<tr>
<td>Herbs and dietary supplements*</td>
<td>Premiums/contributions for COBRA insurance coverage</td>
</tr>
<tr>
<td></td>
<td>Service contracts (dental/ vision)</td>
</tr>
<tr>
<td></td>
<td>Student health fee</td>
</tr>
<tr>
<td></td>
<td>Teeth whitening*</td>
</tr>
<tr>
<td></td>
<td>Travel allowance/ lodging</td>
</tr>
<tr>
<td></td>
<td>for out-of-town medical care*</td>
</tr>
<tr>
<td></td>
<td>Venereis/bonding for cosmetic reason</td>
</tr>
<tr>
<td></td>
<td>Weight loss drugs or programs*</td>
</tr>
<tr>
<td></td>
<td>Warranties/protection plans</td>
</tr>
</tbody>
</table>

*Ineligible unless prescribed for a specific medical condition
Dependent Care Flexible Spending Account

If you pay someone to care for a qualified child, disabled spouse or a qualified relative to enable you (and your spouse, if you are married) to work, you may pay those costs through a pre-tax Dependent Care FSA. Your tax savings can be significant. Read the Internal Revenue Service (IRS) rules summarized below to determine if you can use this account or ask your tax advisor if you have questions. Detailed eligibility information is also available in IRS Publication 503.

Do you meet the qualifications?
The services must:

- enable you and your spouse, or you as a single parent to work, or
- allow you or your spouse to seek employment where earned income equals or exceeds your expenses, or
- enable your spouse to be a full-time student, or
- enable you to provide care for a disabled spouse or qualified individual who is unable to care for themselves in order that you can work.

Who are my qualified individuals?
Qualified individuals for dependent care benefit purposes include your disabled spouse and individuals meeting the IRS definition of Qualified Child* or Qualified Relative** requiring care while you work and spending at least 8 hours per day in your home. The individual may be:

- a child under age 13 at the time of the expense, or
- your spouse or a child of any age who is disabled, or
- a relative or non-relative who 1) receives over half their support from you, and 2) whose gross income is less than the federal exemption amount ($3,200 in 2005).

* A Qualified Child must have a family relationship with you and reside with you for more than half the year.

** A Qualified Relative must have a family relationship with you, share your principle place of abode and be a member of your household without violation of local law.

NOTE: special ordering rules apply for divorced parents. Generally, the parent with whom the child resides with for the longest period of time is entitled to claim the expense, regardless of which parent is the custodial parent or given the tax deduction. Only one taxpayer can claim an individual per tax year for dependent care deduction/tax credit purposes.

These condensed guidelines may not cover everyone's situation. Your tax advisor may be your best resource to determine your qualified individuals for the Dependent Care FSA benefit.

What is the maximum contribution allowed for Dependent Care expenses?
The total pre-tax contribution for any tax year cannot exceed:

- $5,000 or your earned income if less, if you are single, or
- $5,000, or the lesser of your or your spouse's earned income if less than $5,000, if filing a joint return. This maximum is reduced for contributions your spouse makes to a Dependent Care Plan with his or her employer.
- $2,500, or the lesser of your or your spouse's earned income if less than $2,500, when filing separately.

NOTE: earned income for a non-working, full-time student or disabled spouse is deemed to be $250 a month for one qualified individual, and $500 a month for two or more qualified individuals (up to the $5,000 maximum).
Who is considered an ELIGIBLE care provider?
A care provider might be a neighbor, a family member you do not claim a tax exemption for, or a day care center that complies with state and local laws. The expense must be for care of a qualified individual while you, and your spouse if married, are gainfully employed, or actively seeking employment. Some examples are listed below.

Before and after school care (school or private home)  Nursery school
Dependent care facility for a disabled adult or child  Payroll taxes paid to the care provider
In-home care provider  Preschool (education is secondary)
Licensed day care center  Summer/day camp
Neighborhood care provider  (child returns home daily)

What type of expenses are NOT ELIGIBLE?
Non-work related care  Late payment fees
Care provided by your child who is under age 19 or a person you claim an exemption or credit for  Meals, transportation, entertainment and supplies billed separately
Cost of schooling, education or summer school classes  Nursing home care if individual does not return home daily
Expenses to allow volunteer work  Overnight camps
Kindergarten

Am I entitled to other dependent care credits if I contribute to a Dependent Care FSA?
You cannot be reimbursed from your Dependent Care FSA and claim a tax credit for the same expense. A Dependent Care FSA allows a Federal, State and Social Security tax break on up to $5,000 per tax year per family.

Depending on your Dependent Care FSA election and the amount of dependent care expenses actually incurred during the tax year, you may be able to claim part or all of the difference as a Child Care Tax Credit on your federal tax return. For example, if annual day care expenses for one child total $3,800 and you contribute $2,500 to a Dependent Care FSA, you are allowed to claim the tax credit on $500 because the Child Care Tax Credit limit is $3,000 for one qualified individual.

You will be required to file IRS Form 2441 with your annual tax return, identifying your provider(s) Social Security or Tax Identification Number. Talk to your tax advisor about dependent care tax breaks available to you based on the number of qualifying individuals receiving care, the type and amount of dependent care expenses, your adjusted gross income, your filing status and your tax liabilities.
Should I Participate in an FSA?

Participation in a Health Care or Dependent Care FSA is completely optional. Individuals and families with qualified expenses may want to consider taking advantage of this employer-sponsored benefit. The more you contribute the greater your tax benefits, but it is important to realistically estimate your elections. Employees will receive on-line access to view year-to-date and detailed personal account information, download forms and more.

Neither you nor your spouse may contribute to the full-coverage Health Care FSA described in this booklet if either of you contribute or intend to contribute to a Health Savings Account (HSA) during the next plan year. Ask your benefits department if a Limited Health Care FSA option is available. HSA contributions do not impact your Dependent Care FSA.

If you are uncertain about the tax advantages of FSA benefits, or need to clarify who your qualifying individuals are, talk to your tax advisor or accountant. M&I Benefits Services can answer general questions about the plan and eligible health care or dependent care expenses. Client service representatives are available Monday through Friday from 8:00 a.m. – 5:00 p.m. Central Standard Time by calling 1-800-236-3539 (FLEX).

Participants are encouraged to keep this booklet as a reference guide. Detailed instructions about documenting expenses, filing claims and your reimbursements are available on-line and on pages 9 and 10 of this booklet.
Claim Submission and Reimbursements

Complete and Sign a Claim Form
Reimbursement request forms (claim forms) are available on-line at https://www.miwebflex.com. Forms will be mailed or faxed upon request. Participants must sign each form certifying expenses are eligible expenses, are not duplicates, and have not been (and will not be) paid by another source or claimed as a tax credit or deduction.

Complete Section 1 in its entirety. Address changes can be done on-line at https://www.miwebflex.com OR noted on your claim form.

Gather Third-Party Documentation
The IRS requires proof of eligible health care expenses. Documentation is simple when the guidelines below are followed. Generally, your third-party documentation must provide the 1) date of service, 2) type of service, and 3) your out-of-pocket expense. In some cases, we may require additional information to verify an expense was not for general health or cosmetic purposes. When submitting a general health or cosmetic expense, you should include a letter from your physician indicating the condition the expense treats.

HEALTH CARE DOCUMENTATION
• Use insurance Explanation of Benefits (EOB)  
  – when insurance coverage is provided
• Use itemized bills or itemized statements from service providers  
  – when there is NO insurance coverage for an expense (vision, hearing aids, etc.)
• Use co-pay receipts  
  – for office visits or prescriptions
• Use itemized cash register receipts for medicine, drugs and medical supplies  
  – for over-the-counter expenses (cough medicine, contact supplies, pain relievers, etc.)
• Use your treatment plan contract for orthodontic expenses  
  – submit the treatment contract with your first orthodontic claim  
  – use dates and amounts from the contract to request monthly payments thereafter

DAY CARE DOCUMENTATION
• Use third-party receipts/statements as documentation

OR

• Use Section 3 of the claim form as your third-party receipt  
  – have your provider sign the appropriate areas on the claim form  
  – changes must be initialed by the service provider

Submit the Form
Fax, mail or electronically submit your reimbursement request form and respective documentation. Documentation is not returned, so it is best to retain a copy with your tax information for the applicable plan year. There is a $25 minimum service/handling charge for copy requests.

Claims are reviewed and processed within 5 business days of receipt by M&I Benefits Services and are considered “submitted” when received by M&I Benefits Services. If you do not receive reimbursement or a claim denial notice after 15 calendar days, contact M&I Benefits Services at 1-800-236-3539 between 8:00 a.m. and 5:00 p.m. Central Standard Time (Mon – Fri).
Claims can be submitted for reimbursement through the end of the run-off period immediately following plan year coverage. Your Summary Plan Description (SPD) will specify your run-off period. You must file all eligible claims against FSA funds by the end of the run-off period or any account balance will be forfeited. If you lose coverage during the plan year, submit claims as soon as you receive documentation in accordance with your SPD.

Fax Number: 1-888-244-2759 or 920-749-5998
Mail Address: M&I Benefits Services
PO Box 2517
Appleton, WI 54912-2517

Scan electronically and e-mail at https://www.miwebflex.com

Adverse Determination (Claim Denial)
A claim is denied in writing when there is reasonable doubt that an expense qualifies as an eligible expense. The notice will set forth reason(s) for the denial and describe information needed to make the claim whole. When multiple expenses are submitted on one claim, eligible expenses will be processed and only the unacceptable expense will be denied. Many times an Adverse Determination notice is generated because of a simple oversight on the part of the participant.

If you receive an Adverse Determination notice you must appeal in writing within 180 days of notification. The appeal must provide all requested information to validate the expense as a health care or dependent care expense. You lose the right to appeal the denied claim in the future if you do not appeal the denial within the 180 day period.

Appeals are decided within no more than 60 days after receipt. If the second decision affirms the initial adverse determination, a written notice will be sent explaining specific reason(s) for the denial, plan provision(s) the denial is based on, any “internal rule, guideline, protocol, or other similar criterion” used to make the decision, a statement of your right to review relevant documents at no charge upon request and a statement of your right to file suit. This appealed decision is a final determination for the denied expense.

Payment
Claim review and benefit determination is generally made within 5 business days of claim receipt and payment issued no less than once per week. Your SPD will indicate actual reimbursement frequency for your plan. Claims for less than $25 are held until other requests are received. The $25 limit does not apply at year end.

Reimbursement checks are mailed to your home, unless you request direct deposit to your financial institution. Be sure to change your mailing address if you move. Direct deposit transmissions take up to 2 business days from the reimbursement date to reach your financial institution. Verify funds with your institution prior to spending them and notify M&I immediately if you change financial institutions or change/close accounts.

Your entire Health Care FSA election amount is available during the plan year regardless of your cash balance or year-to-date FSA contributions. Dependent Care FSA reimbursements however, are limited to the cash balance on the day of distribution. If day care expenses exceed your cash balance at the time of reimbursement, the unpaid portion will be automatically recalculated and paid after the next payroll contribution is received.

Tracking Your Claim Activity
You can view prior expenses, track account balances and view your most recent reimbursement on-line the day after payment at https://www.miwebflex.com. Keep in mind that it may take up to 5 business days to fully process your request. If you do not have on-line access, you can call 1-800-236-3539 for claim or payment information.